port containing the results of the evaluation conducted under paragraph (1), together with recommendations—

''(A) as to whether the independent monitor program should be established on a permanent basis;

''(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

''(C) for such legislation and administrative action as the Secretary determines appropriate.''

§ 1320a–7k. Medicare and Medicaid program integrity provisions

(a) Data matching

(1) Integrated data repository

(A) Inclusion of certain data

(i) In general

The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

(I) The programs under subchapters XVIII and XIX (including parts A, B, C, and D of subchapter XVIII).

(II) The program under subchapter XXI.

(III) Health-related programs administered by the Secretary of Veterans Affairs.

(IV) Health-related programs administered by the Secretary of Defense.

(V) The program of old-age, survivors, and disability insurance benefits established under subchapter II.

(VI) The Indian Health Service and the Contract Health Service program.

(ii) Priority for inclusion of certain data

Inclusion of the data described in subclause (I) of such clause[1] in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause[1] shall be included in the Integrated Data Repository as appropriate.

(B) Data sharing and matching

(i) In general

The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under subchapters XVIII and XIX.

(ii) Individuals described

The following individuals are described in this clause:

(I) The Commissioner of Social Security.

(II) The Secretary of Veterans Affairs.

(III) The Secretary of Defense.

(IV) The Director of the Indian Health Service.

(iii) Definition of system of records

For purposes of this paragraph, the term ''system of records'' has the meaning given such term in section 552a(a)(5) of title 5.

[1] So in original. Probably should be ''clause (i)''.

(2) Access to claims and payment databases

For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, and subject to any information systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to subchapters XVIII, XIX, and XXI.

(b) OIG authority to obtain information

(1) In general

Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under subchapters XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1320a–7b(f) of this title) regardless of how the item or service is paid for, or to whom such payment is made.

(2) Inclusion of certain information

Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under subchapter XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of subchapter XVIII, a covered part D drug (as defined in section 1395w–102(e) of this title) for which payment is made under an MA–PD plan under part C of such subchapter, or a prescription drug plan under part D of such subchapter, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under subchapters XVIII and XIX.

(c) Administrative remedy for knowing participation by beneficiary in health care fraud scheme

(1) In general

In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

(2) Applicable individual

For purposes of paragraph (1), the term ''applicable individual'' means an individual—

(A) entitled to, or enrolled for, benefits under part A of subchapter XVIII or enrolled under part B of such subchapter;

(B) eligible for medical assistance under a State plan under subchapter XIX or under a waiver of such plan; or

(C) eligible for child health assistance under a child health plan under subchapter XXI.

(d) Reporting and returning of overpayments

(1) In general

If a person has received an overpayment, the person shall—

(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments

An overpayment must be reported and returned under paragraph (1) by the later of—

(A) the date which is 60 days after the date on which the overpayment was identified; or

(B) the date any corresponding cost report is due, if applicable.

(3) Enforcement

Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31) for purposes of section 3729 of such title.

(4) Definitions

In this subsection:

(A) Knowing and knowingly

The terms ''knowing'' and ''knowingly'' have the meaning given those terms in section 3729(b) of title 31.

(B) Overpayment

The term ''overpayment'' means any funds that a person receives or retains under subchapter XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such subchapter.

(C) Person

(i) In general

The term ''person'' means a provider of services, supplier, medicaid managed care organization (as defined in section 1396b(m)(1)(A) of this title), Medicare Advantage organization (as defined in section 1395w–28(a)(1) of this title), or PDP sponsor (as defined in section 1395w–151(a)(13) of this title).

(ii) Exclusion

Such term does not include a beneficiary.

(e) Inclusion of national provider identifier on all applications and claims

The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under subchapters XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.

(Aug. 14, 1935, ch. 531, title XI, § 1128J, as added Pub. L. 111–148, title VI, § 6402(a), Mar. 23, 2010, 124 Stat. 753.)

REFERENCES IN TEXT

The Health Insurance Portability and Accountability Act of 1996, referred to in subsec. (a)(2), is Pub. L. 104–191, Aug. 21, 1996, 110 Stat. 1936. For complete classification of this Act to the Code, see Short Title of 1996 Amendments note set out under section 201 of this title and Tables.

§ 1320a–7*l*. Nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers

(a) In general

The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) Agreements

(A) Newly participating States

The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) Certain previously participating States

The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and